

FILED

APR 03 2017

BEFORE THE  
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

BENNIE S. JOHNSON, D.O.

Osteopathic Physician's and Surgeon  
Certificate No. 20A11324

Respondent.

Case No. 00-2013-003759

OAH No. 2016080801

ORDER OF DECISION

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Osteopathic Medical Board of California, Department of Consumer Affairs, as its Decision in the above-entitled matter.

This Decision shall become effective on May 3, 2017.

IT IS SO ORDERED this 3<sup>rd</sup> day of April 2017.

By: Joseph A. Zammuto  
JOSEPH A. ZAMMUTO, D.O., PRESIDENT  
OSTEOPATHIC MEDICAL BOARD

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**PROPOSED DECISION**

Administrative Law Judge Vallera J. Johnson, State of California, Office of Administrative Hearings, heard this matter in San Diego, California on January 30 and 31, February 1, 2, and 3, 2017.

Jason Ahn, Deputy Attorney General, represented complainant, Angelina Burton, Executive Director of the Osteopathic Medical Board of California.

Bennie S. Johnson, D.O., respondent, was present and represented himself.

The matter was submitted on February 3, 2017.

**FACTUAL FINDINGS**

*Jurisdictional Facts*

1. On July 30, 2010, the Osteopathic Medical Board of California issued Osteopathic Physician's and Surgeon's Certificate No. 20A11324 to Bennie S. Johnson, D.O. At all times relevant, said physician's and surgeon's certificate was in full force and effect and will expire on November 30, 2017, unless renewed or revoked.

2. Angelina M. Burton filed Accusation, Case No. 00-2013-00375, in her official capacity as the Executive Director of the Osteopathic Medical Board of California. In the Accusation, complainant alleged that, in his care and treatment of four patients, respondent engaged in:

- gross negligence when he:
  - ordered, and/or directed and/or approved administration of ultrasound and thermography tests;
  - failed to obtain a history and perform a physical examination before initiating treatment;
  - failed to obtain a history and perform a physical examination, periodically, during treatment.
- repeated negligent acts when he:
  - ordered and/or directed and/or approved administration of one or more unnecessary tests;
  - failed to obtain a history and perform a physical examination before initiating treatment;
  - failed to obtain a history and perform a physical examination, periodically, during treatment;
  - failed to properly monitor patient(s) while on intravenous (IV) therapy;
  - prescribed chemotherapy drugs without adequate training in oncology and without properly monitor the patient(s).

Further, complainant alleged that respondent engaged in conduct which was unbecoming a member in good standing of the medical profession, which demonstrates an unfitness to practice.

Based on the foregoing facts and violations, complainant seeks an order (1) disciplining respondent's physician's and surgeon's certificate, (2) compelling respondent to pay the reasonable costs of investigation and enforcement of the case, and, (3) if respondent is placed on probation, an order compelling respondent to pay the board's cost of probation monitoring.

3. Respondent filed a timely Notice of Defense, requesting a hearing in the matter. He disputed the charges in the accusation.

#### *Respondent's Education, Training & Experience*

4. Respondent testified regarding his education, training and experience.

In 1981, he obtained an osteopathic medical degree from the University of Health Sciences, previously known as Kansas City College of Osteopathic Medicine, in Kansas City, Missouri. In 2001, he graduated from First National University with a doctor of naturopathic medicine; he attended an extension program in Fort Oglethorpe, Georgia. In 2004, respondent obtained a medical degree from the University of Science, Arts and Technology in Montserrat, British West Indies; and, in 2016, he received an honorary post doctorate degree from the same institution.

Between 1981 and 1982, respondent completed a rotating internship at Phoenix General Hospital, in Phoenix, Arizona. Between 1982 and 1984, he worked with a general practice and emergency medicine group. Between 1984 and 1985, he completed a general practice residency at Doctors' Hospital in Tucker, Georgia. In 1985, respondent graduated from flight surgery school and from combat casualty care course, both "put on" by the United States Army. From 1985 until 1998, respondent served as a flight surgeon in the United States Army Reserve. Between 1985 and 1996, he practiced with a general practice and gastroenterology group. Between 1997 and 2004, respondent practiced complementary and alternative medicine at the Immune Recovery Foundation in Atlanta, Georgia. For the past six years, respondent has maintained a solo practice in complementary and alternative medicine in Encinitas, California; he has one patient. Between 2012 and 2013, he worked at pH Miracle Center.

In 1998, respondent received a clinical thermologist certification from the American College of Clinical Thermology.

Respondent was first licensed as a doctor of osteopathic medicine in 1984. In addition to California, respondent is licensed as an osteopathic physician in the states of Tennessee, Georgia, Colorado, Arizona and North Carolina. His license is active and current in California and Georgia. There is no evidence of prior discipline by any board in any state.

At the University of Science, Arts and Technology, respondent is on the academic committee – medicine; the committee is responsible for oversight of the teaching curricula for medicine. In addition, he is a tenured professor of medicine at the same institution; in this capacity, he teaches subjects related to oncology and complimentary medicine in Fort Lauderdale, Florida, every two to three months. He is a board member of Best Answer for Cancer, an independent group that provides alternative cancer treatment. Since 2015, he has held a cabinet position as Minister of Health with the Southern Cherokee Nation.

In 2016, respondent received the lifetime achievement award from President Obama. Respondent did not explain the basis for the award.

Respondent testified that he has written books about the issues in this case. He did not state the names of the books or provide other evidence about the books.

### *Standard of Care*

5. To ascertain the facts, the standard of care and whether respondent's care and treatment of patients involved a deviation from the standard of care and, if so, the extent of the deviation, the testimonial and documentary evidence have been considered. Complainant called Christine S. Nguyen, M.D. as her expert witness. Respondent did not call an expert witness but questioned the reliability of complainant's expert's qualifications, her opinions, and the bases for her opinions.

6. Dr. Nguyen's qualifications have been evaluated.

In 1991, she obtained her medical degree from University of Texas Medical Branch. Between 1991 and 1994, Dr. Nguyen completed her internship and residency at the University of California - Irvine in internal medicine.

Since 1993, Dr. Nguyen has been licensed as a physician and surgeon by the Medical Board of California.

Since 1996, Dr. Nguyen has been certified by the American Board of Internal Medicine.<sup>1</sup> Between 2001 and 2015, she has been certified by the American Board of Acupuncture. Between 2009 and 2016, she was certified by the American Board of Integrative Holistic Medicine.

Since 1994, Dr. Nguyen has been in private practice in internal medicine. Since 2012, she has been in practice in internal medicine at the University of California - San Diego Health System.

Dr. Nguyen has hospital privileges at Tri-City Medical Center in Oceanside and University of California Medical Center, Thornton Hospital in La Jolla.

She serves as a mentor for the American Board of Integrative Holistic Medicine.

7. Dr. Nguyen has served as an expert witness on behalf of the board since 2013 and has provided opinions in five cases. In 50 percent of the cases, she determined the physician "to be at fault" and in 50 percent, she determined the physician was "not at fault". This is the first case in which she has testified. She has not provided opinions in criminal or civil cases.

8. Respondent questioned Dr. Nguyen's qualifications to serve as the expert witness. He argued that she is an allopathic physician, not an osteopathic physician. In response, complainant explained that Dr. Nguyen had been certified by the American Board of Integrative Holistic Medicine and that she mentored students who are preparing for this

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<sup>1</sup> Dr. Nguyen was recertified in 2006 and again in 2016.

board certification. Further, pursuant to Business and Professions Code<sup>2</sup> section 3600-2, the standard of care to be applied in proceedings before the board was the standard provided by Dr. Nguyen. For the foregoing reasons, respondent's argument was rejected.

9. Respondent challenged the bases for Dr. Nguyen's opinions. He argued that he took a history and performed a physical examination on each of the patients identified in this case and that the documentation was missing from the record and obtained during a search and seizure of pH Miracle Center.

In July 2013, with a search warrant, investigators from the San Diego County District Attorney's Office searched a storage facility that contained, among other things, medical records of pH Miracle Center patients. Those medical records were transferred to the board and are exhibits in this case.

Considering respondent's allegation regarding missing records, the administrative law judge ordered complainant to obtain an affidavit from the District Attorney's Office that stated that all the seized medical records were included in this case; in the alternative if there were missing documents that the additional documents be provided. To provide the affidavit, the investigator and deputy district attorney reviewed the patient records in this case and compared these documents to the documents in custody of the district attorney's office. Rather than provide the declaration, both the investigator and deputy district attorney testified in this case. The investigator stated that the deputy district attorney was most knowledgeable about the chain of custody of the medical records.

Gina Darvus, the deputy district attorney who handled the criminal investigation, explained the procedure she followed. When the documents were seized, the documents were reviewed by the investigator, a paralegal and the deputy district attorney. The documents were imaged and bates stamped. In this case, Ms. Darvus reviewed the exhibits and then verified the bates stamped numbers. Further, Ms. Darvus explained that the files were "often commingled" and "disorganized", not in chronological order. So, Ms. Darvus used the adobe function on her computer to search by patient name. She found additional medical records for this case mixed in the files of other patient medical records. The new records were marked as exhibits 4A, 5A, 6A and 7A and admitted into evidence.

None of the new medical records, for the patients in this case, documented history and/or physical examinations performed by respondent.

Dr. Nguyen properly relied on the medical records provided to her. She reviewed the additional records provided by the deputy district attorney. Dr. Nguyen found no basis to change any opinion.

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<sup>2</sup> Hereinafter, all reference is to the Business and Professions Code unless otherwise stated.

10. Complainant offered no evidence to establish that respondent ordered the diagnostic ultrasound and thermography and/or any other ultrasounds. There is no dispute that respondent was the only physician who worked at pH Miracle Center between June 2012 and July 2013. Initially, respondent stated that he had no memory of who ordered the tests and that he may have ordered some of the tests; then he stated that the tests could have been ordered by the patients or Robert Young, Ph.D. because a physician's order is not required. In some cases, Dr. Young's name is listed as the physician. In some records, no name is listed for the person who ordered the test.

In this case, Universal Medical Imaging Group performed the diagnostic ultrasound and thermography and the additional ultrasounds, and respondent, doing business as Dr. Ben Johnson Services LLC, interpreted the tests. Though respondent's credibility is questionable, it was not established that respondent ordered the diagnostic ultrasound and thermography and/or additional ultrasounds for the four patients identified in this case. Therefore Dr. Nguyen's opinions regarding the full body diagnostic ultrasound and thermography and other ultrasounds for the four patients is disregarded.

11. Dr. Nguyen was qualified to serve as an expert witness in this case. She had the appropriate education, training and experience (23 years of practice in internal medicine) to render opinions. She was familiar with the relevant procedures and issues in this case. She relied on reasonable information (medical records of the patients) in rendering her opinions. She understood the standard of care, simple departure and extreme departure from the standard of care. There was no evidence that she was an advocate for complainant or was otherwise biased. Her testimony was clear, logical and easy to understand. In addition, when she felt that it was not clear, she gave respondent the benefit of the doubt and did not find that he committed a violation. As such, Dr. Nguyen's testimony was reliable, trustworthy and credible.

After reviewing the patients' medical records, Dr. Nguyen issued a report, dated January 24, 2016, and a supplemental report, revised February 4, 2016.

12. The testimony of Dr. Nguyen and respondent was evaluated. For the reasons stated in Finding 11, Dr. Nguyen's testimony was reliable, trustworthy and credible.

On the other hand, in some cases, by contrast, respondent's testimony was confusing, evasive and inconsistent. In his closing argument, respondent argued that he was attempting to be truthful but under stress, he had stage fright, so his mind went blank. Considering the foregoing facts, his testimony was difficult to assess.

FACTS REGARDING PATIENTS R.K., M.K., N.H. AND D.K.

*Patient R.K.*

13. Prior to receiving care at pH Miracle Center in August 2012, patient R.K. had been diagnosed with right breast cancer and had had a lumpectomy.

14. On August 27, 2012, patient R.K. began receiving medical care at pH Miracle Center. There is no documentary evidence that, prior to commencing treatment, respondent obtained a history or performed a physical examination of patient R.K.

15. During treatment, respondent did not obtain a history or conduct a physical examination of patient R.K., periodically.

16. On August 27, 2012, a full body medical diagnostic ultrasound and thermography were ordered on patient R.K. Respondent interpreted the foregoing test. Based on the results, respondent made recommendations that included:

- Breast Ultrasound;
- Abdominal and Pelvic Ultrasound;
- Colon, gallbladder, and liver cleanser;
- Proper Hydration and exercise; and
- Consultation with a qualified health care professional on environmental, lifestyle, and nutritional practices to support breast health and consideration of preventative treatment.

17. On August 27, 2012, the following tests were ordered on patient R.K.: Bilateral lower extremity venous ultrasound, bilateral lower extremity arterial ultrasound, bilateral breast ultrasound, and carotid ultrasound. Respondent interpreted the foregoing tests.

18. On August 29, 2012, respondent ordered administration of intravenous therapy (IV therapy) on patient R.K. Respondent prescribed 50 mL of Sodium Bicarbonate, 10 mL of Magnesium Chloride, and 5 mL of N-Acetylcysteine. This IV therapy was administered on August 29, 30 and 31, and September 1, 3, 4, 5, 6, 7 and 8, 2012. There was minimal, if any, monitoring of patient R.K.

19. On September 3, 2012, a full body medical diagnostic ultrasound and thermography (breast and abdomen) on patient R.K. was ordered. Respondent interpreted the test.

20. On September 10, 2012, a full body medical diagnostic ultrasound and thermography (breast and abdomen) was ordered. Respondent interpreted the test. Based on the results of the full body medical diagnostic ultrasound and thermography, respondent made recommendations that included:



- Breast Ultrasound;
- Proper hydration and exercise; and
- Consultation with a qualified health care professional on environmental, lifestyle and nutritional practices to support breast health and consideration of preventative treatment.

### *Gross Negligence*

21. There is no evidence in patient R.K.'s medical record that respondent took a history and/or performed a physical examination prior to commencement of treatment of patient R.K.

Expert testimony established that, prior to commencing treatment, a physician must take a thorough history and perform a complete physical examination. The purpose of doing so is to establish the physician/patient relationship; the physician needs to learn as much as possible about the patient to formulate a diagnosis and treatment plan. In addition, it is important information for subsequent health care providers who may later become involved in the care and treatment of the patient.

Expert testimony established that a reasonably careful and prudent physician would not fail to take a history and perform a physical examination prior to commencement of treatment. Therefore, respondent's failure to do so constituted an extreme departure from the standard of care.

22. Also, there is no evidence in patient R.K.'s medical record that, while providing care and treatment for patient R.K., respondent periodically took a follow-up history and performed a follow-up physical examination.

Expert testimony established that the standard of care required a treating physician to obtain a follow-up history and perform a follow-up physical examination periodically. The frequency of the foregoing varies depending on the patient's condition. At least one follow-up examination should be done to determine if the treatment prescribed is working or if there are side effects.

Expert testimony established that a reasonably careful and prudent physician would have obtained a history and performed a physical examination periodically after initiation of treatment. Therefore, respondent's failure to do so when he provided care and treatment for patient R.K. constituted an extreme departure from the standard of care.

### *Repeated Negligent Acts*

23. Based on respondent's order, patient R.K. received IV therapy for 10 days.

Expert testimony established that the standard of care required that, when IV therapy was administered every day, the patient was required to be monitored to ensure that she was not receiving too much fluids; if fluids had been accumulated in the lungs, it could have caused pulmonary edema; fluid in the lungs are a symptom of heart failure. The monitoring required includes the following.

- The patient's input (the amount of fluid taken in orally and as well as output (urine) was required to be monitored;
- The patient was required to be examined for symptoms of fluid overload (such as swelling in the legs, crackles in the lungs, and/or shortness of breath); and
- The patient was required to be weighed on a weekly basis to ensure that she was not gaining weight from too much fluid.

In Dr. Nguyen's opinion, respondent's failure to monitor patient R.K.'s IV fluid intake constituted repeated negligent acts.

Respondent testified that, beyond normal monitoring by the nurse who administered IV therapy, monitoring of a patient who received IV therapy was not necessary. He explained that normally an individual drinks one gallon of fluid every day; the amount of fluid was one-eighth the normal intake. Patient R.K. was ambulatory, not lying in bed in the hospital. Therefore, the administered IV therapy did not present an imminent threat to patient R.K. As such, he did not monitor patient R.K. in the manner described by Dr. Nguyen.

Despite respondent's testimony, Dr. Nguyen's opinion did not change.

Expert testimony established that, when respondent failed to monitor R.K. after administration of IV therapy on 10 separate occasions, respondent engaged in repeated negligent acts.

24. In his care and treatment of patient R.K., respondent engaged in repeated negligent acts in that:

- He did not obtain a history or conduct a physical examination before commencing treatment; and
- During treatment, he failed to obtain a history or conduct physical examinations periodically.

*Patient M.K.*

25. Prior to receiving medical care at pH Medical Center, patient M.K. had a history of bladder cancer and kidney cancer with metastases to the spine, liver, and lungs. She had had multiple surgeries, radiation treatments, and multiple small bowel obstructions due to adhesions.

26. On July 15, 2012, patient M.K. began receiving medical care at pH Miracle Center. Prior to initiating treatment, respondent did not obtain a history or perform a physical examination.

27. On July 16, 2012, a full body medical diagnostic ultrasound and thermography was ordered. Respondent interpreted the test. Based on the results, respondent recommended, among other things:

- Breast Ultrasound;
- Abdominal and Pelvic Ultrasound;
- Colon, gallbladder, and liver cleanses;
- Proper hydration and exercise; and
- Consultation with a qualified healthcare professional on environmental, lifestyle and nutritional practices to support breast health and consideration of preventative treatment.

28. On July 16, 2012, bilateral lower extremity venous ultrasound, thyroid ultrasound, carotid ultrasound, bilateral breast ultrasound, bladder ultrasound, abdominal ultrasound, and bilateral lower extremity arterial ultrasound tests were ordered for patient M.K. Respondent interpreted the results of these tests.

29. On July 23, 2012, a full body medical diagnostic ultrasound and thermography (abdomen, back and neck) was ordered on patient M.K. Respondent interpreted this test. Based on the results of this test, among other things, respondent recommended:

- Proper hydration and exercise; and
- Consultation with a qualified health care professional on environmental, lifestyle and nutritional practices to support breast health and consideration of preventative treatment.

30. On July 23, 2012, respondent ordered IV therapy on patient M.K. He prescribed 500 mL of 0.45 percent saline, 75 mL of Sodium Bicarbonate, 10 mL of

Magnesium Chloride twice daily. This IV therapy commenced on August 6, 2012. Patient M.K. received this IV therapy on August 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 26, 27, 28, 30 and 31, and September 1, 2, 3, 4, 5, 7, 8, 21, 22, 26, 28, 29 and 30, 2012. There was minimal monitoring, if any, of patient M.K.

31. Also, on July 23, 2012, respondent issued a standing order<sup>3</sup> for chemotherapy drugs for patient M.K. Specifically, he prescribed 2 mL of Cisplatin and 2 mL of Cyclophosphamide once a week. When he issued the order, respondent had no special training or fellowship in oncology. He did not monitor patient M.K. or ask about possible side effects of the medication.

32. On July 30, 2012, a full body medical diagnostic ultrasound and thermography (abdomen, back and neck) on patient M.K. was ordered. Respondent interpreted the test. Based on the results, among other things, respondent recommended:

- Proper hydration and exercise; and
- Consultation with a qualified health care professional on environmental, lifestyle, and nutritional practices to support breath health and considerations of preventative treatment.

33. On August 6, 2012, a full body medical diagnostic ultrasound and thermography (abdomen, back and neck) test was ordered. Respondent interpreted the results of the test. Based on the test results, among other things, respondent recommended:

- Proper hydration and exercise; and
- Consultation with a qualified health care professional on environmental, lifestyle, and nutritional practices to support breath health and considerations of preventative treatment.

34. On August 6, 2012, respondent modified his order for administration of IV therapy for patient M.K. He added 4 mL of DMSO and 2 mL of Cesium. There was minimal, if any, monitoring of patient M.K.

### *Gross Negligence*

35. Respondent committed gross negligence in the care and treatment of patient M.K. which included the following:

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<sup>3</sup> A standing order is intended to continue unless modified or changed by the physician who issued the order.

- Prior to initiating treatment, he did not obtain a history or perform a physical examination of patient M.K.;<sup>4</sup>
- During treatment, respondent did not obtain a history or perform a physical examination of patient M.K., periodically;<sup>5</sup> and

36. Complainant alleged that, when respondent prescribed chemotherapy for patient M.K., he engaged in gross negligence because he had no special training and had not done a fellowship in oncology; further, respondent did not properly monitor patient M.K. after administration of the chemotherapy drugs.

The standard of care is for a general practitioner to refer a patient to an oncologist for the ordering of administration of chemotherapy medications because these drugs (such as Cyclophosphamide and Cisplatin) are powerful drugs that are tailored to treat different types of cancers. There are side effects and different abnormalities that are caused by these drugs, such as vomiting, bone marrow suppression, kidney failure, infection, and hemorrhagic cystitis. Therefore, the patient needs to be monitored for the side effects. Proper monitoring following the administration of chemotherapy drugs includes ordering a complete blood count to check kidney function (for kidney failure), checking the patient's urine (for hemorrhagic cystitis/blood in urine which can be fatal) and regularly taking a history and performing a physical examination (to monitor for infection).

In Dr. Nguyen's opinion, prescribing chemotherapy drugs without a fellowship in oncology constitutes an extreme departure from the standard of care; ordering the administration of chemotherapy drugs without proper monitoring constitutes an extreme departure from the standard of care.

On September 27, 2012, there was one laboratory test for kidney function. There is no other evidence in the medical record that respondent monitored patient M.K. while she was receiving chemotherapy drugs. Dr. Nguyen could not ascertain from M.K.'s medical records whether respondent ordered and/or reviewed the kidney test performed on September 27, 2012. However, in her opinion, even if he had reviewed the foregoing information, it would have been inadequate monitoring of a patient receiving chemotherapy drugs.

Respondent argued that the dosage of chemotherapy drugs was low, did not cause the possible symptoms experienced with higher dosages of chemotherapy medications and therefore did not require the monitoring described by Dr. Nguyen. Considering the foregoing, Dr. Nguyen did not change her opinion.

Therefore, respondent's order to administer chemotherapy drugs for patient M.K. without having completed a fellowship in oncology constituted an extreme departure from

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<sup>4</sup> This is based on paragraph 21 of the Factual Findings.

<sup>5</sup> This is based on paragraph 22 of the Factual Findings.

the standard of care. The lack of proper monitoring of patient M.K. after ordering administration of chemotherapy drugs constituted an extreme departure from the standard of care.

*Repeated Negligent Acts*

37. In his care and treatment of patient M.K., respondent engaged in repeated negligent acts in that:

- He did not obtain a history or conduct a physical examination before commencing treatment; and
- During treatment, he failed to obtain a history or conduct physical examinations periodically.
- He failed to properly monitor patient M.K. while on IV therapy;<sup>6</sup> and
- He prescribed chemotherapy drugs (2 mL of Cisplatin and 2 mL of Cyclophosphamide) to patient M.K. without adequate training in Oncology and proper monitoring of patient M.K.

*Patient N.H.*

38. Prior to receiving medical care at pH Medical Center, patient N.H. had been diagnosed with left breast cancer in November 2010. She had undergone left breast mastectomy and radiation therapy. The cancer recurred in April 2012 and was widely metastatic.

39. On July 30, 2012, patient N.H. began receiving medical care at pH Miracle Center. Prior to initiating treatment, respondent did not obtain a history or perform a physical examination on patient N.H.

40. During treatment of patient N.H., respondent did not obtain a history or perform physical examination periodically.

41. On July 30, 2012, a full body medical diagnostic ultrasound and thermography of patient N.H. was ordered. Respondent interpreted the test. Based on the results, among other things, he recommended:

- Magnetic resonance imaging test;
- Breast Ultrasound;

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<sup>6</sup> This is based on paragraph 24 of the Factual Findings.

- Abdominal and Pelvic Ultrasound;
- Colon, gallbladder, and liver cleanses;
- Proper alkaline hydration, diet and exercise;
- Consultation with a qualified health care professional on environmental, lifestyle and nutritional practices to support breast health and consideration of preventative treatment.

42. On August 27, 2012, a full body medical diagnostic ultrasound and thermography was ordered on patient N.H. Respondent interpreted the test.<sup>7</sup> Based on the results, among other things, respondent recommended:

- MRI;
- Breast Ultrasound;
- Abdominal and Pelvic Ultrasound;
- Colon, gallbladder, and liver cleanses;
- Proper alkaline hydration, diet and exercise;
- Consultation with a qualified health care professional on environmental, lifestyle and nutritional practices to support breast health and consideration of preventative treatment.

43. Respondent issued an undated order for the administration of IV therapy for patient N.H. twice daily. He prescribed 500 mL of 0.45 percent normal saline, 100 mL of Sodium Bicarbonate, 10 mL of Magnesium Chloride, N-Acetylcysteine, Glutathione, Phosphatidylcholine and Insulin. Patient N.H. received the IV therapy on August 1, 6, 8, 9, 10 (once), 11 (once), 13, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, September 1, 3, 4, 5, 6 (once), 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 (once), 17, 18 (once), 19, 20 (once), 21 (once), 22, 23 (once), 26 (once), 28 (once), 29 (once), 30 (once), October 2 (once), 3 (once), 4 (once), 5 (once), 6 (once), 9 (once), 12, 13, 14, and 15 (once).

During the time that patient N.H. received IV therapy, ordered by respondent, respondent's weight was documented three times, on September 5, October 1 and October 14, 2014. There is no evidence that respondent reviewed these weights. In Dr. Nguyen's

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<sup>7</sup> The report for the examination states the date of the examination as July 30, 2012. In the body of the report, there is a comparison between the July 30 and August 27, 2012. At the bottom of the report is the date of August 30, 2012.

opinion, these weights are not sufficient monitoring of patient N.H.'s weight during the time that she was receiving IV therapy.

It appears that, on October 4, 2012, a modified physical examination was performed. There were abdominal, vaginal, breast and lung examinations. The upper lungs are noted as clear. Patient N.H. was not asked about shortness of breath. No patient name, no name of provider or signature is on the documented examinations. There is no evidence that respondent ordered or performed this physical examination. Neither respondent's name nor signature or other evidence indicated that respondent reviewed the documented examinations.

Respondent did not properly monitor patient N.H. while she received IV therapy.

44. On October 16, 2012, respondent prescribed 1mL of Cisplatin. There is no evidence that the patient received treatment on more than one occasion.

#### *Gross Negligence*

45. Respondent committed the following acts of gross negligence in the care and treatment of patient N.H.:

- Prior to initiating treatment, he did not obtain a history or conduct a physical examination of patient N.H.;<sup>8</sup>
- During treatment, respondent did not obtain a history or conduct a physical examination of patient N.H., periodically;<sup>9</sup> and
- Without a prior fellowship in oncology, he prescribed a chemotherapy drug to patient N.H.<sup>10</sup>

There is no evidence that the chemotherapy drug was administered on more than one occasion to patient N.H. Based on Dr. Nguyen's description of and required frequency of monitoring, insufficient evidence was offered to establish that monitoring was required after administration of the chemotherapy drug on one occasion. As such, it was not established that respondent engaged in gross negligence when he did not monitor patient N.H.

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<sup>8</sup> This is based on paragraph 21 of Factual Findings.

<sup>9</sup> This is based on paragraph 22 of Factual Findings.

<sup>10</sup> This is based on paragraph 36 of Factual Findings.



### *Repeated Negligent Acts*

46. Respondent committed repeated negligent acts in his care and treatment of patient N.H. which included the following:

- Before initiating treatment on patient N.H., he did not obtain a history or conduct a physical examination;
- During treatment of patient N.H, he did not obtain a history or conduct a physical examination, periodically;
- After ordering IV therapy for patient N.H., he did not properly monitor patient N.H. while she was on IV therapy;<sup>11</sup> and
- He ordered a chemotherapy drug for patient N.H. without having an oncology fellowship or other oncology training.

There is no evidence that the chemotherapy drug was administered on more than one occasion to patient N.H. Based on Dr. Nguyen's description of and required frequency of monitoring, insufficient evidence was offered to establish that monitoring was required after administration of the chemotherapy drug on one occasion. As such, it was not established that respondent engaged in a negligent act when he did not monitor patient N.H.

### *Patient D.K.*

47. Prior to receiving care at pH Miracle Center, patient D.K. had a history of left breast cancer. In August 2012, patient D.K. had a left breast lumpectomy.

48. On September 7, 2012, patient D.K. began receiving medical care at pH Medical Center. Before initiating treatment on patient D.K., respondent did not obtain a history or perform a physical examination.

49. On September 7, 2012, patient D.K. began treatment at pH Medical Center. There is no evidence that respondent took a history or performed a physical examination prior to initiating treatment of patient D.K.

50. There is evidence that, during treatment, respondent obtained a history or performed a physical examination periodically.

51. On September 7, 2012, a full body medical diagnostic ultrasound and thermography was ordered on patient D.K. Respondent interpreted the results of the test. Based on the results, among other things, respondent recommended:

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<sup>11</sup> This is based on paragraph 24 of Factual Findings.

- Thyroid Ultrasound;
- Breast Ultrasound;
- Abdominal and Pelvic Ultrasound;
- Colon, gallbladder, and liver cleanses;
- Proper alkaline hydration and exercise; and
- Consultation with a qualified health care professional on environmental, lifestyle, and nutritional practices to support breast health and consideration of preventive treatment.

52. On February 12, 2013, respondent ordered administration of IV therapy on patient D.K. He prescribed 500 mL of 0.45 percent normal saline, 150 mL of Sodium Bicarbonate, and 10 mL of Magnesium Chloride. There are no records that IV therapy was administered.

#### *Gross Negligence*

53. Respondent committed the following acts of gross negligence in the care and treatment of patient D.K.:

- Prior to initiating treatment, he did not obtain a history or perform a physical examination of patient D.K.;<sup>12</sup> and
- During treatment, respondent did not obtain a history or perform a physical examination of patient D.K., periodically.<sup>13</sup>

#### *Repeated Negligent Acts*

54. Respondent committed repeated negligent acts in his care and treatment of patient D.K. which included the following:

- Before initiating treatment, he did not obtain a history or perform a physical examination;
- During treatment, he did not obtain a history or perform a physical examination, periodically;

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<sup>12</sup> This is based on paragraph 21 of the Findings of Fact.

<sup>13</sup> This is based on paragraph 22 of the Findings of Fact.

Respondent ordered IV therapy for patient D.K. There is no evidence that she received the treatment. Therefore, monitoring was not necessary. As such, failure to monitor did not constitute a deviation from the standard of care.

#### *General Unprofessional Conduct*

55. Based on the facts in this case, it was established that respondent breached the rules or ethical code of the medical profession or conduct which is unbecoming a member in good standing of the medical profession and which demonstrates unfitness to practice.

#### *Costs of Investigation and Enforcement*

56. In support of the request for costs of investigation and prosecution, complainant filed declarations to seek costs related to the investigation and prosecution of this matter. In its declaration, the costs incurred by the Division of Investigations were \$8,404, which includes expert reviewer costs of \$2,700. The costs incurred by the Attorney General's Office, for 2016/17, are \$24,522.50.

Respondent asserted that he had no objection to the reasonableness of the costs because he could not verify whether the services were performed or not.

### LEGAL CONCLUSIONS

#### *The Purpose of Disciplinary Proceedings*

1. The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

#### *Statutory Authority*

2. Code section 3600 states: "The law governing licentiates of the Osteopathic Medical Board is found in the Osteopathic Act and in Chapter 5 of Division 2, relating to medicine."

3. Code section 3600-2 states:

The Osteopathic Medical Board of California shall enforce those portions of the Medical Practice Act identified as Article 12 (commencing with Section 2220), of Chapter 5 of Division 2 of the Business and Professions Code, as now existing or

hereafter amended, as to persons who hold certificates subject to the jurisdiction of the Osteopathic Medical Board of California, however, persons who elect to practice using the term or suffix "M.D." as provided in Section 2275 of the Business and Professions Code, as now existing or hereafter amended, shall not be subject to this section, and the Medical Board of California shall enforce the provisions of the article as to persons who make the election. After making the election, each person so electing shall apply for renewal of his or her certificate to the Medical Board of California, and the Medical Board of California shall issue renewal certificates in the same manner as other renewal certificates are issued by it.

4. Code section 2227 states that a licensee who is found guilty under the Medical Practice Act may have his license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded or have such other action taken in relation to discipline as the medical board deems proper.

5. Code section 2234 of the Code states, in part:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to the following:

[¶] . . . [¶]

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited

to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care. . .

#### Case Law

6. When a physician assumes care for a patient, he has a duty to provide care that is within accepted standards. Moreover, "[t]here is no profession where the patient passes so completely within the power and control of the operator as does the medical patient." (*Fuller v. Board of Medical Examiners* (1936) 14 Cal.App.2d 734, 741-742.) A patient, being unlearned in the medical sciences, must depend on the inherent trust underlying the patient-physician relationship. Indeed, as the California Supreme Court has stated: "... the patient is fully entitled to rely upon the physician's skill and judgment while under his care, and has little choice but to do so." (*Sanchez v. South Hoover Hospital* (1976) 18 Cal.3d 93, 102.)

7. It is well-settled that "a physician or surgeon [must] have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient . . ." (*Huffman v. Lindquist* (1951) 37 Cal.2d 465, 473, insert added, see also *Flowers v. Torrance Memorial Hospital Medical Center*, *supra*, 8 Cal.4th at 998.) Whether he has done so in a particular case is generally a question for experts and can be established only by their testimony unless the matter in issue is within the common knowledge of laymen. [citation]" (*Trindle v. Wheeler* (1943) 23 Cal.2d 330, 333.)

8. Pursuant to Code section 2234, subdivision (b), the commission of gross negligence in the practice of medicine constitutes unprofessional conduct. Gross negligence is "an extreme departure from the ordinary standard of care." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 198.) "[N]egligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm." (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997, citation omitted.)

9. A physician is not necessarily negligent because he errs in judgment or because his efforts prove unsuccessful. He is negligent only if his error in judgment or lack of success is due to a failure to perform any of the duties required of reputable members of his profession practicing in the same or similar locality under similar circumstances. (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337; *Black v. Caruso* (1960) 187 Cal.App.2d 195.)

10. Pursuant to Code section 2234, subdivision (c), the commission of repeated negligent acts in the practice of medicine constitutes unprofessional conduct. Repeated negligent acts are two or more grossly or ordinarily negligent acts. Such acts need not be "similar" or part of a "pattern" in order to constitute repeated negligent acts. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

### *Violations*

11. Cause exists to discipline respondent's certificate for unprofessional conduct under Code sections 2227 and 2234, in that he committed gross negligence in his care and treatment of patients R.K., M.K., N.H. and D.K.

12. Cause exists to discipline respondent's certificate for unprofessional conduct under Code sections 2227 and 2234, in that he committed repeated negligent acts in his care and treatment of patients R.K., M.K., N.H. and D.K.

13. Pursuant to Code section 2234, cause exists to discipline respondent's certificate in that he engaged in conduct that breached the rules of ethical conduct of the medical profession and conduct that is unbecoming a member in good standing of the medical profession and that demonstrates an unfitness to practice medicine. (*Windham v. Board of Medical Quality Assurance* (1980) 104 Cal.App.3d 461, 470.)

### *Appropriate Measure of Discipline.*

14. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Conduct supporting the revocation or suspension of a medical license must demonstrate unfitness to practice. The purpose of a disciplinary action is not to punish, but to protect the public. In an administrative disciplinary proceeding, the inquiry must be limited to the effect of the doctor's actions upon the quality of service to his patients. (*Watson v. Superior Court* (2009) 176 Cal.App.4th 1407, 1416.) Because the main purpose of license discipline is to protect the public, patient harm is not required before the board can impose discipline. It is far more desirable to impose discipline on a physician before there is patient harm than after harm has occurred. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772-773).

15. Rehabilitation requires a consideration of those offenses from which one has allegedly been rehabilitated. (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1048.) Rehabilitation is a state of mind, and the law looks with favor upon rewarding with the opportunity to serve one who has achieved reformation and regeneration. (*Id.*, at 1058.) The absence of a prior disciplinary record is a mitigating factor. (*Chefsky v. State Bar* (1984) 36 Cal.3d 116, 132, fn. 10.) Remorse and cooperation are mitigating factors. (*In re Demergian* (1989) 48 Cal.3d 284, 296.) While a candid admission of misconduct and full acknowledgment of wrongdoing may be a necessary step in the rehabilitation process, it is only a first step. A truer indication of rehabilitation is presented if an individual demonstrates by sustained conduct over an extended period of time that he is once again fit to practice. (*In re Trebilcock* (1981) 30 Cal.3d 312, 315-316.)

16. Respondent has been licensed to practice medicine for more than 22 years, has been licensed in several states and has been licensed in California for six years. There is no evidence of prior discipline in California or any other state.

Complainant established that, in his care and treatment of four patients, respondent engaged in gross negligence and repeated negligent acts in that:

- Prior to commencement of treatment, he failed to obtain a history or perform a physical examination;
- During treatment, he failed to obtain a history or perform a physical examination;
- He ordered administration of chemotherapy medications without having completed training or fellowship as an oncologist;
- He failed to properly monitor patients after ordering administration of chemotherapy drugs;
- He failed to monitor patients after ordering administration of IV therapy.

The incidents in this case occurred almost five years ago and involved ill vulnerable patients.

There is no evidence that respondent appreciates or understands that he engaged in gross negligence and repeated negligent acts in his care and treatment of the patients. There is no evidence that he has changed his practice of medicine. There is no evidence that respondent has taken steps to assure that he does not make the same mistakes in the future. Further, respondent challenged the board's jurisdiction, questioning the board's authority over his practice of medicine. As such, there is no evidence that he would comply with the terms and conditions of probation. Considering the foregoing, it was not established that respondent is rehabilitated; and, it would be contrary to the public interest to allow respondent to retain his physician's and surgeon's certificate to practice medicine.

#### *Costs*

17. Code section 125.3 states in part:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

[¶] . . . [¶]

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General. . . .

18. The Office of Administrative Hearings has enacted a regulation for use when evaluating an agency's request for costs under Code section 125.3. (Cal. Code Regs., tit. 1, § 1042.) Under the regulation, a cost request must be accompanied by a declaration or certification supporting the costs incurred.

19. In this case, complainant seeks costs related to the investigation and prosecution of this matter in the amount of \$32,926.50. In support of the request, complainant submitted a certification of costs of investigation and a declaration from the deputy attorney general who prosecuted the case.

*Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32 held that a regulation imposing costs of investigation and enforcement under California Code of Regulations, title 16, section 317.5 (similar to Bus. & Prof. Code, § 125.3), did not violate due process. But, it was incumbent on the board in that case to exercise discretion to reduce or eliminate cost awards in a manner such that costs imposed did not "deter [licensees] with potentially meritorious claims or defenses from exercising their right to a hearing." The Supreme Court set forth four factors to consider in deciding whether to reduce or eliminate costs: (1) whether the licensee used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed; (2) whether the licensee had a "subjective" good faith belief in the merits of his position; (3) whether the licensee raised a "colorable challenge" to the proposed discipline; and (4) whether the licensee had the financial ability to make payments. The reasoning of *Zuckerman* must be applied to Business and Professions Code section 125.3 since the cost recovery regulation in *Zuckerman* contains substantially the same language as that is set forth in Code section 125.3.

The Accusation alleged three causes for discipline, based on facts involving four patients. Many of the violations were not established. Respondent used the hearing process to obtain a reduction of the charges. In addition, he had a "subjective" good faith belief in the merits of his position. No evidence was offered regarding respondent's ability to pay. Considering the foregoing and the factors discussed in *Zuckerman*, the reasonable costs of investigation and enforcement are \$20,000.

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## ORDER

1. Osteopathic Physician's and Surgeon's Certificate Number 20A11324 issued to Bennie S. Johnson is revoked.

2. No later than 90 days from the effective date of this decision, respondent shall reimburse the board's cost of investigation and enforcement in the amount of \$20,000.

DATED: March 6, 2017

DocuSigned by:  
*Vallera J. Johnson*  
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VALLERA J. JOHNSON  
Administrative Law Judge  
Office of Administrative Hearings

**DECLARATION OF SERVICE BY MAIL**

**In the Matter of the Accusation Against:**

**Bennie S. Johnson, D.O.  
Case No: 00-2013-003759**

I, the undersigned, declare that I am over 18 years of age and not a party to the within cause; my business address is 1300 National Drive, Suite 150, Sacramento, CA 95834. I served a true copy of the attached:

**DECISION  
PROPOSED DECISION**

by mail on each of the following, by placing it in an envelope (or envelopes) addressed (respectively) as follows:

**NAME AND ADDRESS**

**CERT NO.**

Bennie S. Johnson, D.O.  
2210 Encinitas Blvd. Suite T  
Encinitas, CA 92024

91 7199 9991 7036 9572 4533


Each said envelope was then, on April 3, 2017 sealed and deposited in the United States mail at Sacramento, California, the county in which I am employed, with the postage thereon fully prepaid and return receipt requested.

Executed on April 3, 2017 at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Steve Ly

\_\_\_\_\_  
Typed Name

  
\_\_\_\_\_  
Signature

cc: The Honorable Vallera J. Johnson, Administrative Law Judge  
Jason Ahn, Deputy Attorney General